No. 83-2136

In the Supreme Court of the United States

OCTOBER TERM, 1984

STATE OF CONNECTICUT, DEPARTMENT OF INCOME MAINTENANCE, PETITIONER

v.

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, AND THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE RESPONDENTS

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QUESTION PRESENTED

Whether "intermediate care facilities" (ICFs) that are primarily engaged in the diagnosis, treatment, or care of the mentally ill also may be classified as "institutions for mental diseases" (IMDs) under the Medicaid statute, thereby rendering such ICFs subject to the statutory ban against Medicaid coverage for services rendered to persons over age 21 and under age 65 in an IMD.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-16a) is reported at 731 F.2d 1052. The opinion of the district court (Pet. App. 1c-25c) is reported at 557 F. Supp. 1077. The opinion of the Departmental Grant Appeals Board of the United States Department of Health and Human Services (Pet. App. 1d-61d) is not reported.

JURISDICTION

The judgment of the court of appeals (Pet. App. 1b-2b) was entered on March 30, 1984. The petition for a writ of certiorari was filed on June 28, 1984, and was granted on October 29, 1984. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTE INVOLVED

Relevant provisions of the Medicaid statute, Title XIX of the Social Security Act, as amended, 42 U.S.C. 1396 *et seq.*, as further amended by the Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, 98 Stat. 1061 *et seq.*, are reproduced as Appendix A to this brief.

STATEMENT

Petitioner brought this action to challenge the disallowance of federal Medicaid reimbursement for services provided to patients at Middletown Haven Rest Home, a state-licensed "intermediate care facility" (ICF). The Secretary of Health and Human Services concluded that the disallowance was mandated after an audit revealed that the "overall character" of Middletown Haven is that of an "institution for mental diseases" (IMD), for which Medicaid reimbursement is barred by statute. While not disputing the fact that Middletown Haven specializes in the care and treatment of the mentally ill, petitioner contends that IMDs encompass only traditional mental hospitals and argues that an ICF can never be an IMD, regardless of its "overall character" as a facility established and maintained primarily for the care and treatment of the mentally ill.

A. The Statutory And Regulatory Scheme

1. The Medicaid program was established pursuant to Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*, "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris* v. *McRae*, 448 U.S. 297, 301 (1980). To participate in the program, a state must develop a Medicaid plan that is consistent with the requirements of Title XIX and federal regulations promulgated thereunder. 42 U.S.C. 1396a. See *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 37 (1981). Following approval of the plan by the Secretary of Health

and Human Services, the state is entitled to federal financial assistance in the provision of medical care to eligible individuals who are covered by the state plan. 42 U.S.C. 1396a.

The Medicaid statute specifically excludes from coverage services provided to any person more than 21 and under 65 years of age who is a patient in an "institution for mental diseases" (IMD). 42 U.S.C. 1396d(a). The statute defines "medical assistance" for which federal financial participation is available to include inpatient hospital services, skilled nursing facility (SNF) services, and intermediate care facility (ICF) services, other than such services provided in an institution for mental diseases. 42 U.S.C. 1396d(a)(1), (4)(A), and (15). Payments for services to individuals under age 65 who are patients in an IMD (other than inpatient psychiatric care for persons under age 21) are further specifically prohibited by 42 U.S.C. 1396d(a)(B).

2. The history of the so-called IMD exclusion dates back to 1950. In that year, Congress adopted a system of federal grants to the states for the operation of state programs to aid the permanently and totally disabled. The statute establishing the grant program specifically excluded payments on behalf of "any individual * * * who is a patient in an institution for * * * mental diseases." Social Security Act Amendments of 1950, ch. 809, § 351, 64 Stat. 558. When "medical assistance" for the aged was added to the grant program in 1960, that term was similarly defined to exclude payments for "care in behalf of * * * any individual who is a patient in an institution for * * * mental diseases." Social Security Amendments of 1960, Pub. L. No. 86-778, § 601(f)(1) and (2), 74 Stat. 991.[1]

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[1] Congress did authorize coverage for up to six weeks of care in a *medical* institution for eligible individuals of any age diagnosed as having a psychosis. Social Security Amendments of 1960, Pub. L. No. 86-778, § 601(f)(1) and (2), 74 Stat. 991.

When Congress enacted the Medicaid program in 1965, Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 *et seq.*, it retained the general bar against payments for services rendered in IMDs. Section 121(a), § 1905(a)(1), (4), and (B), 79 Stat. 351-352.[2] This exclusion was based on Congress's understanding that the long-term care of patients in mental institutions "had traditionally been accepted as a responsibility of the States." S. Rep. 404, 89th Cong., 1st Sess. 144 (1965); see *id.* at 146; H.R. Rep. 213, 89th Cong., 1st Sess. 126, 128 (1965). For the first time, however, Congress provided Medicaid coverage for needy individuals over age 64 in institutions for mental diseases (Section 121(a), § 1905(a)(14), 79 Stat. 352). As a condition of extending coverage to those over age 64 in IMDs, Congress required participating states to develop plans for the use of other forms of care for the aged mentally ill and to conduct initial and periodic reviews of each elderly patient to ensure appropriate treatment for each individual. Section 121(a), § 1902(a)(20), 79 Stat. 347; S. Rep. 404, *supra*, at 145. As yet a further condition on the extension of IMD coverage to the elderly, Congress required participating states to demonstrate satisfactory progress toward developing and implementing comprehensive mental health programs. Section 121(a), § 1902(a)(21), 79 Stat. 347. This requirement was intended to ensure that "States move ahead promptly to develop comprehensive mental health plans as contemplated in the Community Mental Health Centers Act of 1963 [Pub. L. No. 88-164, Tit. II, 77 Stat. 290 *et seq.*]." S. Rep. 404, *supra*, at 146.[3]

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[2] Congress did authorize Medicaid coverage for the eligible mentally ill in general hospitals and general SNFs. Section 121(a), § 1905(a)(1) and (4), 79 Stat. 351. See S. Rep. 404, 89th Cong., 1st Sess. 144, 216-217 (1965).

[3] The Community Mental Health Centers Act, and its relevance to the question presented in this case, is discussed in detail at pages 16, 39-41 & note 31, *infra*.

In 1971, Congress amended the definition of "medical assistance" under the Medicaid program to include ICF services.[4] Pub. L. No. 92-223, § 4(a)(2), 85 Stat. 809. As with inpatient hospital services and skilled nursing facility services, which had been considered "medical assistance" under the Medicaid program since its enactment in 1965, the 1971 ICF provision contained a specific exclusion for ICF services in IMDs, an exclusion that remains in the statute today (42 U.S.C. 1396d(a)(15)).[5]

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[4] ICF services had been covered under the programs of cash assistance for the aged, blind, and disabled since 1967. Pub. L. No. 90-248, § 250, 81 Stat. 920-921. As previously noted (see page 3, *supra*), these cash assistance programs excluded payments made for the care of individuals in IMDs. Nothing in the 1967 legislation adding ICF coverage to the cash assistance programs altered the blanket IMD exclusion for persons under age 65.

[5] In the same Act (Pub. L. No. 92-223, § 4(a)(2), 85 Stat. 809, codified at 42 U.S.C. 1396d(d)), Congress provided that ICF services for which federal financial assistance is available could include "services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions." Congress specified that the primary purpose of such an institution (or distinct part thereof) had to be the provision of health or rehabilitative services for mentally retarded individuals, that mentally retarded individuals for whom federal assistance was requested had to be receiving active treatment, and that states could not use federal money to reduce their own expenditures with respect to the mentally retarded. *Ibid.*

Congress was aware that the medical profession viewed mental retardation differently from mental illness; it was told that the mentally retarded are persons suffering from " 'subaverage general intellectual functioning which originates during the developmental period and is associated with impaired adaptive behavior.' " *Social Security Amendments of 1970: Hearings on H.R. 17550 Before the Senate Comm. on Finance*, 91st Cong., 2d Sess. 506 (1970) (statement of Dr. Kenneth Gaver, Administrator, Oregon Division of Mental Health) (citation omitted). Dr. Gaver went on to state that (*ibid.*):

> [Institutions for the mentally retarded] use different methods than do mental hospitals. * * * They focus on different goals. Their concern is to train the mentally retarded person

In 1972, Congress further broadened the class of mentally ill patients eligible for Medicaid coverage by extending benefits to children. Social Security Amendments of 1972, Pub. L. No. 92-603, § 299B(a) and (b), 86 Stat. 1460-1461. The 1972 amendments extended Medicaid coverage to persons under age 21 who are inpatients in psychiatric hospitals, provided, inter alia, that the treatment they are receiving is certified as being likely to improve their condition.

3. Congress has never defined the term "institution for mental diseases." The Secretary, however, has defined IMDs by regulation. Shortly after enactment of the Medicaid program in 1965, the Secretary provided that federal reimbursement could not be claimed for:

> Any individual who has not attained 65 years of age and is a patient in an institution * * * for mental diseases; i.e., an institution whose overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases (whether or not it is licensed).

U.S. Dep't of Health, Education, and Welfare, *Handbook of Public Assistance Administration, Supplement D—Medical Assistance Programs Under Title XIX of the Social Security Act* ¶ D-4620.2 (1966) [hereinafter cited as *HPA*].[6] The *HPA* was later replaced with formal

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to his maximum level of personal independence and to place him in a community setting if possible.

See also 117 Cong. Rec. 44720 (1971) (remarks of Sen. Bellmon) ("[T]here are public institutions whose primary objective is the active provision of rehabilitative, educational and training services to enhance the capacity of mentally retarded individuals to care for themselves or to engage in employment. [Such] institutions * * * should be subject to Federal participation under adequate safeguards.").

[6] The 1966 *HPA* also defined an IMD as an institution that met "the requirements for a psychiatric hospital under title XVIII, section 1861(f), of the Social Security Act," or, for a three-year period only, was approved by appropriate state agencies as "a hospital established for the care of the mentally ill." *HPA* ¶ D-5141.14.d. At the time this definition was adopted, however, ICFs were not encompassed within the Medicaid program, and there is little, if any, evidence to show that significant numbers of SNFs were primarily engaged in the care and treatment of mental patients. See Br. for the American Psychiatric Ass'n et al. at 8.

regulations. Regulations promulgated in 1969 essentially restated the *HPA* definition of an IMD in negative fashion; that is, the regulations provided that covered "'[i]npatient hospital services' are those items and services ordinarily furnished by the hospital for the care and treatment of inpatients * * * *in an institution maintained primarily for treatment and care of patients with disorders other than * * * mental diseases.*" 34 Fed. Reg. 9785 (1969), codified at 45 C.F.R. 249.10(b)(1)(1970) (emphasis added). Similarly, skilled nursing home services were defined as "those items and services furnished by a skilled nursing home *maintained primarily for the care and treatment of inpatients with disorders other than * * * mental diseases.*" 34 Fed. Reg. 9785 (1969), codified at 45 C.F.R. 249.10(b)(4)(1) (1970) (emphasis added).[7]

In 1971, the Secretary promulgated regulations dealing generally with "institutional status." With respect to IMDs in particular, the 1971 regulations provided (36 Fed. Reg. 3872 (1971), codified at 45 C.F.R. 248.60(a)(3)(ii) and (b)(7) (1972)):

> Whether an institution is one for * * * mental diseases will be determined by whether its overall

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[7] Like the *HPA*, the 1969 regulations also defined an IMD as an institution meeting the requirements of the Social Security Act for a psychiatric hospital or, for a temporary period only, an institution certified by an appropriate state agency as a hospital established for the care of the mentally ill. 34 Fed. Reg. 9787 (1969), codified at 45 C.F.R. 249.10(b)(14)(iv) (1970). See note 6, *supra*. This definition was eliminated in 1974, when the agency promulgated regulations to implement the statutory transfer of ICF coverage from the old cash assistance programs to the Medicaid program. See 39 Fed. Reg. 2221 (1974), and compare 45 C.F.R. 249.10(b)(14)(iv) (1973) with 45 C.F.R. 249.10(b)(14)(iv) (1974).

> character is that of a facility established and maintained primarily for the care and treatment of individuals with * * * mental diseases (whether or not it is licensed);
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> * * * * *
>
> "Institution for mental diseases" means an institution which is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services.[8]

The current definition of an IMD substantially tracks the original definition contained in the 1966 *HPA* and carried forward in subsequent regulations. An IMD is defined as (42 C.F.R. 435.1009(e)):

> an institution[9] that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

The Secretary has supplemented this definition with a series of field staff instructions that describe the relevant criteria to be considered in determining whether or not the "overall character" of a facility is that of an IMD. These criteria instruct audit teams to focus on the following characteristics of an institution under review (Pet. App. 5a n.2):

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[8] In 1977 and 1978, the applicable regulations were redesignated and recodified without substantive change as part of Title 42 of the Code of Federal Regulations. See 42 Fed. Reg. 52826 (1977); 43 Fed. Reg. 45176 (1978).

[9] An "institution" is defined as any establishment that furnishes food, shelter, and some treatment or services to four or more persons unrelated to the proprietor. 42 C.F.R. 435.1009(e).

1. Licensed as a mental institution.

2. Advertised as a mental institution.

3. More than 50% of the patients have a disability in mental functioning.

4. Used by mental hospitals for alternative care.

5. Patients who may have entered mental hospitals are accepted directly from the community.

6. Proximity to State mental institutions (within a 25 mile radius).

7. Age distribution uncharacteristic of nursing home patients.

8. Basis of Medicaid eligibility for patients under 65 is due to mental disability.

9. Hires staff specialized in the care of the mentally ill.

10. Independent professional reviews conducted by state teams report a preponderance of mental illness among patients in the facility.

B. The Facts Of This Proceeding

The State of Connecticut brought this action in the United States District Court for the District of Connecticut, seeking review of a decision by the Department of Health and Human Services (HHS) disallowing federal financial assistance claimed by Connecticut under the Medicaid program for services provided to patients at Middletown Haven Rest Home, a private long-term care facility. The facility was certified by the State as an ICF during the fiscal quarters at issue here, from January 1977 through September 1979. The State received $1,634,655 in federal financial assistance for payments it made to Middletown Haven during those quarters.

1. Federal payments to the State on behalf of Middletown Haven came under scrutiny in December 1979, when an audit team from HHS undertook a detailed review

of the facility (Pet. App. 4a-5a). The review was part of a much larger study conducted to determine whether certain states, including Connecticut, "were discharging patients from mental hospitals and arranging their placement in ICF's in order to circumvent the Medicaid exclusion for patients under 65 in IMD's" (*id.* at 5a). Both HHS and the General Accounting Office had learned that a number of states were replacing large mental hospitals with smaller institutions, such as SNFs and ICFs, thereby changing the character of these smaller facilities into IMDs. J.A. 1d, 6d-7d.

Applying the criteria developed by HHS to supplement the regulatory definition of an IMD (see page 9, *supra*), an audit team consisting of a psychiatrist, psychiatric nurse, auditor, financial management consultant, and Medicaid program specialist conducted an extensive review of Middletown Haven to determine whether it was an IMD (J.A. 3a). The team examined the facility's license and staffing procedures (J.A. 9a); reviewed Independent Professional Review (IPR) reports and Medical Review (MR) reports prepared by the State (J.A. 9a-10a);[10] and held discussions with the facility's owner, administrator, and staff, and with state medical and financial personnel (J.A. 10a).

In addition, the psychiatrist and psychiatric nurse conducted a detailed review of the facility's patient records in order to determine patient diagnoses (J.A. 9a). From three sources—Middletown Haven's patient log, a patient census report prepared by Middletown Haven for the Connecticut Department of Health, and Medicaid claims paid—the audit team assembled a list of patients treated in the facility since it had opened in January 1977 (J.A. 15a-16a). The psychiatrist devised a protocol for reviewing the medical records of these patients. In

[10] IPR and MR reports are reviews conducted by state personnel of every Medicaid patient in facilities certified by a state as Medicaid eligible. The reviews are required by statute (42 U.S.C. 1396a(a)(26)(A) and (31)(A)) and regulation (42 C.F.R. Pt. 456).

74 sample cases on which the protocol was tested, all three reviewers (the psychiatrist, the psychiatric nurse, and the Medicaid program specialist) arrived independently at the same diagnosis (J.A. 16a). Concluding that the sample cases validated the review methodology, the same method was then used to evaluate the remaining 395 patients (*ibid.*). If there was "even the slightest possibility of a question" in a particular case, the case was referred to the psychiatrist for final determination (*ibid.*). In such cases, the psychiatrist often consulted with the facility's staff (C.A. App. 64-65).

Patient diagnoses were classified according to the " 'International Classification of Diseases, Adapted for Use in the United States,' Eighth Revision, Public Health Service Publication No. 1693" (Pet. App. 21d & n.19, 42d n.29). The diagnoses most frequently reported by the State itself, and with which the audit team agreed, were schizophrenia, paranoia, psychotic depressive reaction, depression psychosis, acute dissociative reaction, manic depressive psychosis, catatonic schizophrenia, and alcoholism with acute brain syndrome (J.A. 23a).

The audit team determined, based on the criteria developed to identify IMDs (see page 9, *supra*), that Middletown Haven met the definition of an IMD set forth at 42 C.F.R. 435.1009(e). The team noted that some of the factors carried greater weight than others (J.A. 13a), and it explained the importance attached to each factor (J.A. 13a-24a). The audit team's major findings were as follows (J.A. 13a-24a; Pet. App. 40d-44d):

> 1. Seventy-seven percent of the patients in the facility during the period January 1977 to December 1979 had a major mental illness that was a substantial part of their need for ongoing care. Even if those patients with primary diagnoses of alcoholism or organic brain syndrome were excluded, the majority of patients were placed in the facility because of mental illness.
>
> 2. More than 50% of the patients had been admitted directly from state mental hospitals.

3. The facility is located only three miles from a state mental hospital and was used by that hospital and two other mental hospitals as an alternative placement site. Of 209 patients at Middletown Haven during fiscal year 1978, 167 came directly from state mental hospitals. An additional 42 came from other institutions (hospitals, SNFs, ICFs, residential facilities). Only four patients came directly from their homes. Whatever their previous placement, all patients had diagnoses similar to those of the patients admitted from the state mental hospital.

4. The age distribution in the facility was uncharacteristic of general nursing home populations. The average nursing home patient in the United States is approximately 82, and 63% are over age 65. At Middletown Haven, the distribution pattern was reversed; 64% of the population was between the ages of 22 and 64.

5. The facility's license from the State contained a "psychiatric rider" authorizing it to "care for persons with certain psychiatric conditions."

6. The facility advertised itself to the community and to potential sources of referral as a facility specializing in mental diseases.

7. The facility hired medical and other staff with specialized training and experience in the care of the mentally ill. The facility employed three physicians to provide services to its patients, and all three were psychiatrists. Even the non-medical staff were informed at the time they were hired of the emphasis on psychiatric conditions and were selected on the basis of their ability to deal with that situation. All employees participated in in-service training for the care of the mentally ill. Staff members indicated that they believed Middletown Haven was a psychiatric facility.

8. The facility's admissions policy stated that all patients "must be certified to be ambulatory and able to care for themselves," indicating that the patients

were not institutionalized primarily for physical illnesses.

9. A sample of reports of the medical reviews performed by the State indicated that 65% of the patients were found to have a primary or single diagnosis of psychiatric condition as the basis for their disability eligibility under Medicaid.

10. State employees conducted four independent professional reviews during the period in question, examining each patient's diagnosis, medication, and history. These reviews documented an increasing percentage of patients with mental diagnoses, ranging from 55% to 67% of the Medicaid patient population. The amount of psychotropic drugs used also indicated a high percentage of psychiatric patients in the facility.

Based on these facts, more fully set forth in its report, the audit team concluded that Middletown Haven was primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases and was, therefore, an "institution for mental diseases" for purposes of the Medicaid statute. HHS then notified the State that it was disallowing the federal financial assistance previously paid to the State for services rendered at Middletown Haven (J.A. 1e).

2. Connecticut appealed the disallowance to the HHS Departmental Grant Appeals Board pursuant to 45 C.F.R. Pt. 16. Connecticut's appeal was consolidated with the appeals of three other states (Minnesota, Illinois, and California) seeking review of findings that certain facilities in those states were IMDs. The Board upheld all of the disallowances, finding substantial evidence in the record that the "overall character" of each of the facilities was such that it met the regulatory definition of an IMD (Pet. App. 1d-61d). The Board's decision constituted the final agency decision.

3. Connecticut sought judicial review of the Secretary's decision in the district court. The district court granted Connecticut's motion for summary judgment (Pet. App.

1c-25c), holding that the IMD exclusion in the Medicaid statute "excludes only care in mental hospitals, meaning care in facilities which, at the least, provide total care to mental patients" (*id.* at 25c).[11]

The court of appeals reversed (Pet. App. 1a-16a). Relying on the language and legislative history of the IMD exclusion, the court rejected Connecticut's contention that "the IMD exclusion was intended to foreclose federal financial assistance only for services provided in traditional state mental hospitals" (*id.* at 7a). The court noted that the provisions of 42 U.S.C. 1396d "are meaningless unless some ICF's are IMD's and thus subject to the statutory exclusion" (Pet. App. 10a). Accordingly, the court concluded that Congress intended the IMD exclusion "to block the use of Medicaid funds to help pay for the care of the mentally ill under 65 in a broad range of institutions subsumed under the label 'institutions for mental diseases,' including ICF's" (*id.* at 15a), and that "the IMD definition adopted by HHS and supplemented by its internal criteria reasonably implements Congress' intent" (*ibid.*).

INTRODUCTION AND SUMMARY OF ARGUMENT

I. Before delving into the Byzantine structure of the Social Security Act, it is appropriate to place Connecticut's rather sweeping generalizations about congressional intent in some perspective. Connecticut does not deny that Middletown Haven specializes in the care and treatment of the mentally ill. Nevertheless, Connecticut argues that the IMD exclusion is limited to traditional mental hospitals and that an ICF can never be an IMD, no matter what its "overall character." Connecticut relies (Br. 16-

[11] The district court's "total care" concept appears nowhere in the statute, regulations, or legislative history. Moreover, "total care," as defined by the district court, appears to have little or nothing to do with any particular level of *psychiatric* care (see Pet. App. 14c). Instead, the district court defined "total care" as "the very high level of care given, for example, to a hospital inpatient or a nursing home resident. The patient is totally dependent on the institution and is submerged in it" (*id.* at 7c n.9).

17) on two assumptions made by Congress in the 1950's about mental hospitals: (1) that the care of patients in such facilities was traditionally a state responsibility and (2) that Congress wanted to encourage the development of "alternatives" to traditional mental hospitals because it viewed those facilities as mere "dumping grounds" for the mentally ill. Both of these assumptions may be accepted as true (although the second is no longer valid), but it does not follow that Congress has ever expressed an intent to extend Medicaid coverage to the mentally ill under age 65 in "alternative" facilities such as ICFs. On the contrary, Congress's cautious approach to increasing federal financial support for the mentally ill requires the opposite conclusion.

Looking first at the cost of caring for the mentally ill, there is ample evidence that Congress always has been reluctant to shift that fiscal responsibility from the states to the federal government. Initially, Congress refused to fund services for any category of the mentally ill. See page 3, *supra*. In its first major step away from that blanket prohibition, Congress provided coverage for the needy aged. It did so in recognition of the fact that health costs for the elderly are a particularly serious problem (S. Rep. 404, *supra*, at 277 (supplemental views); *Social Security Amendments of 1970: Hearings on H.R. 17550 Before the Senate Comm. on Finance*, 91st Cong., 2d Sess. 535 (1970) [hereinafter cited as *1970 Hearings*]) and also in recognition of the fact that it is often difficult to tell the difference between senility and mental illness (110 Cong. Rec. 21349 (1964) (remarks of Sen. Carlson)). Importantly, however, Congress imposed specific standards designed to ensure that the aged mentally ill received treatment appropriate to their needs. See 42 U.S.C. 1396a(a)(20) and (21).

Congress's next major break from the blanket prohibition against funding for the mentally ill came in 1972 when it authorized Medicaid coverage for persons under age 21 receiving inpatient psychiatric services. Congress took this step in recognition of the fact that short-term

treatment, if provided at an early enough age, is "a more efficient investment and has greater potential" for success than treatment for older persons. *1970 Hearings* 534. Again, however, Congress imposed specific restrictions on reimbursement for the treatment of mentally ill children to ensure that such treatment was in fact beneficial and cost-effective. In order to be eligible for Medicaid coverage, the child-patient must be receiving active treatment that can reasonably be expected to improve the patient's condition, such that the services will eventually become unnecessary. 42 U.S.C. 1396d(h). Once more, Congress's concern for the protection of the public fisc is evident.

In the case of the mentally ill between the ages of 21 and 64, on the other hand, Congress has never taken any affirmative action to provide blanket Medicaid coverage for the treatment of their mental conditions. In light of Congress's demonstrated concern for cost-effectiveness in the case of the elderly and those under 21, it would be surprising indeed to conclude that Congress intended open-ended funding for those between the ages of 21 and 64, without regard to the efficacy of the treatment, simply because the patients were residing in facilities other than traditional mental hospitals. Such a result is all the more improbable in light of the fact that Congress has, in the Community Mental Health Centers Act and the block grant program of which it is now a part (see note 31, *infra*), provided for the treatment of the chronically mentally ill without regard to age. Under that program, however, Congress again took pains to specify standards designed to ensure therapeutic and cost-effective treatment. 42 U.S.C. 300x-4(c)(5). Although the Medicaid program contains general standards that ICFs and SNFs must meet, conspicuously absent from the statute is any specific provision for therapeutic and cost-effective treatment of mental illness in such facilities. Such an omission should not be attributed to congressional inadvertence in light of Congress's demonstrated concern with efficacy and cost-effectiveness in other mental illness programs.

Moreover, the potential cost to the federal government that would flow from acceptance of Connecticut's argument is staggering. In the consolidated decision of the Departmental Grant Appeals Board in this action (Pet. App. 1d-61d), over $9 million in disallowances was at stake for 18 facilities in four states over a two-year period. HHS advises us that there are hundreds of ICFs around the country that should be audited to determine whether their "overall character" is that of an IMD. If even a fraction of these audits resulted in such a determination, but the Secretary were required to reimburse the states in any event, the federal financial burden obviously would be enormous. In the absence of any affirmative indication that Congress meant to undertake such a substantial obligation, this Court should defer to the reasonable interpretation of the Secretary that gives full effect to Congress's step-by-step expansion of federal financial assistance for the mentally ill. See *Schweiker* v. *Wilson*, 450 U.S. 221, 238-239 (1981).

It is also true that Congress's original reluctance to provide any funding for the mentally ill stemmed from its perception (perhaps accurate at the time) that state mental institutions were not providing therapeutic treatment but instead did little more than furnish custodial care in dismal surroundings. But that is no longer the situation today. Significant improvements have been made in the treatment provided by large mental hospitals. See pages 35-36, *infra*. Notwithstanding these welcome changes, Connecticut does not dispute the fact that the IMD exclusion remains fully applicable for persons aged 21 to 64 receiving services in traditional mental hospitals. See Pet. Br. 6. If, as Connecticut argues, Congress wanted to avoid paying only for non-therapeutic custodial care, then it is reasonable to assume that Congress would have lifted or relaxed the IMD exclusion insofar as it applies to traditional mental hospitals, at least to a degree commensurate with the improvement in treatment now offered by those facilities. That it has not, despite several requests to do so (see pages 30-31, *infra*), is persuasive

evidence that the Secretary's interpretation of the statute is correct.

II. A. Policy considerations aside, the plain language of the statute supports the Secretary's interpretation of the IMD exclusion. In defining "medical assistance" for which Medicaid reimbursement is available, the statute lists separately "inpatient hospital services," "intermediate care facility services," and "skilled nursing facility services," and contains a separate and unequivocal exclusion from *each* type of service for individuals in IMDs. 42 U.S.C. 1396d(a)(1), (4)(A), and (15). If Congress had intended to limit IMDs to mental hospitals, there would have been no reason to exclude IMDs from the definitions of covered services in other types of facilities. Moreover, Congress expressly used the term "psychiatric hospital" when it intended to refer to a traditional mental hospital. 42 U.S.C. 1396d(h). That it did not do so in the IMD exclusion is strong evidence that the Secretary's focus on the "overall character" of an institution, rather than its label, is precisely what Congress intended.

B. The legislative history of the IMD exclusion fully supports the Secretary's interpretation of the statute. Connecticut relies almost entirely on legislative history demonstrating Congress's intent to lift the IMD exclusion for the *elderly*, a point not at issue in this litigation. The absence of any comparable legislative history with respect to the mentally ill between the ages of 21 and 64 is fatal to Connecticut's argument, especially in light of the fact that Congress declined on three separate occasions to extend the same benefits to those under 65 that it had already provided for the elderly.

C. There is no merit to Connecticut's contention that in the years after Medicaid was first enacted the Secretary interpreted the IMD exclusion as being limited to traditional mental hospitals. From the beginning, the Secretary has identified IMDs by looking to the "overall character" of an institution to determine whether it is engaged primarily in the care and treatment of the mentally ill. The Secretary's consistently-held functional

approach, rather than Connecticut's mechanical labeling of facilities, best comports with congressional intent.

III. A. Connecticut's argument that the disallowance at issue contravenes the principles of "federalism" that underlie the Medicaid program is not properly before this Court. Connecticut's petition for a writ of certiorari raised a single issue—whether, as a matter of statutory construction, the IMD exclusion is limited to traditional mental hospitals. Accordingly, the Court should not consider Connecticut's new contention that the challenged disallowance is an "after-the-fact" action that is inconsistent with the federal-state "contract" created by the Medicaid program.

B. Even if Connecticut's new argument had been properly preserved, it is erroneous. There is no merit to the assertion that the Secretary's interpretation of the IMD exclusion took Connecticut by surprise. In addition to the Secretary's long-standing regulation defining IMDs in terms of their "overall character," Connecticut itself admits (Br. 95 n.74) that it became aware of the Secretary's position in 1976, *i.e.*, before it incurred the expenditures at issue in this litigation. Nor is there any impropriety in the Secretary's retroactive disallowance of nonreimbursable expenditures. On the contrary, the Medicaid statute expressly directs the Secretary to conduct post-expenditure audits to ensure that funds previously advanced to the states were properly spent. If they were not, the Secretary is required to recoup the misspent funds. 42 U.S.C. 1396b(d)(1) and (5). Thus, the Secretary followed precisely the course mandated by Congress. See *Bell* v. *New Jersey*, 461 U.S. 773, 780-783 (1983).

ARGUMENT

I. THE TERM "INSTITUTION FOR MENTAL DISEASES" IS NOT LIMITED TO LARGE, TRADITIONAL MENTAL HOSPITALS

It is undisputed that the Medicaid statute prohibits federal reimbursement for services to individuals over age 21 and under age 65 who are patients in an "institution

for mental diseases" (IMD). 42 U.S.C. 1396d(a).[12] Congress did not define the term "IMD," but it did give the Secretary of HHS broad discretion to interpret and administer the statute. 42 U.S.C. 1302. As this Court has noted, the "Social Security Act is among the most intricate ever drafted by Congress." *Schweiker* v. *Gray Panthers*, 453 U.S. 34, 43 (1981). For that reason, especially heightened deference is due the Secretary's interpretation of the Act. *Id.* at 43-44.[13] As we demonstrate below, the Secretary's conclusion that ICFs and IMDs are not mutually exclusive is a wholly rational interpretation of the statute that should be upheld by this Court.

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[12] This Court has upheld the constitutionality of this prohibition. See *Legion* v. *Richardson*, 354 F. Supp. 456 (S.D.N.Y.), aff'd *sub nom. Legion* v. *Weinberger*, 414 U.S. 1058 (1973); see also *Schweiker* v. *Wilson*, 450 U.S. 221 (1981); *Kantrowitz* v. *Weinberger*, 388 F. Supp. 1127 (D.D.C. 1974), aff'd, 530 F.2d 1034 (D.C. Cir.), cert. denied, 429 U.S. 819 (1976).

[13] Although the Medicaid statute does not expressly delegate to the Secretary authority to define IMDs (compare *Schweiker* v. *Gray Panthers*, 453 U.S. at 43-44), the absence of a statutory definition necessarily required action by the Secretary to fill the void left by Congress. Such action was authorized by 42 U.S.C. 1302, which directs the Secretary to promulgate rules and regulations necessary to the efficient administration of the Social Security Act. We submit that the extraordinary complexity of the statute requires reviewing courts to give greater deference to the Secretary's interpretations under this general rulemaking authority than might be the case with a more straightforward statute. See *Board of Governors of Federal Reserve System* v. *Investment Co. Institute*, 450 U.S. 46, 56 & n.21 (1981). In any event, so long as the agency's interpretation of the statute is a reasonable one, a court may not substitute its own construction for that of the agency. See *Chevron U.S.A. Inc.* v. *Natural Resources Defense Council, Inc.*, No. 82-1005 (June 25, 1984), slip op. 4-7.

Connecticut's argument (Br. 108-118) that no deference is owed to the Secretary's interpretation in this case because that interpretation represents a change in position and is contrary to congressional intent is erroneous. See pages 35-43, *infra*.

A. The Secretary's Interpretation Of The Term "IMD" Is Supported By The Plain Language Of The Statute

1. "[T]he starting point for interpreting a statute is the language of the statute itself." *Consumer Product Safety Commission* v. *GTE Sylvania, Inc.*, 447 U.S. 102, 108 (1980).[14] Although the Medicaid statute does not define the term "institution for mental diseases," the manner in which Congress used that term throughout the statute demonstrates that Congress did not intend IMDs and ICFs to be mutually exclusive or to limit IMDs to traditional mental hospitals. On the contrary, the statutory IMD exclusion clearly encompasses other types of institutions providing services primarily to the mentally ill, including ICFs and SNFs.

a. In defining medical assistance for which Medicaid reimbursement is available, the statute lists separately "inpatient hospital services," "intermediate care facility services," and "skilled nursing facility services," and contains a separate and unequivocal exclusion from *each* type of service for individuals in IMDs. 42 U.S.C. 1396d (a)(1), (4)(A), and (15). The statute clearly excludes Medicaid reimbursement for services in IMDs for *each* type of facility, not just hospitals. By listing hospital services separately from SNF and ICF services, and excluding each type of service in an IMD, Congress necessarily stated in Section 1396d(a) that a particular ICF or SNF can, under some circumstances, also be an IMD. As the court of appeals observed (Pet. App. 9a-10a), if IMDs referred only to hospitals, there would be no reason

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[14] Connecticut purports to agree with this well-settled principle (Br. 29). Nevertheless, virtually all of Connecticut's argument focuses on legislative history, rather than the language of the statute. Indeed, Connecticut's first argument is a lengthy exegesis of the legislative history of the IMD exclusion going back to 1950, when ICFs did not even exist (Br. 24-49). Moreover, as we show in Point I(B), *infra*, the legislative history upon which Connecticut relies does not support its reading of the statute.

to exclude IMDs from the definitions of other types of covered services. The statutory language could hardly be more clear.

If the language of Section 1396d(a)(1), (4)(A), and (15) were not sufficient, other sections of the statute repeat the IMD exclusion in terms that make clear its applicability to all types of institutions. For example, 42 U.S.C. 1396d(a)(B) contains a blanket prohibition on medical assistance payments for services to individuals under age 65 who are patients in an IMD, thereby reinforcing the plain meaning of the specific exclusions contained in Section 1396d(a)(1), (4)(A), and (15). Moreover, at the same time that Section 1396d(a)(B) *excludes* from Medicaid coverage care or services in IMDs for those under 65, 42 U.S.C. 1396d(a)(14) *includes* services for those over 65 by authorizing Medicaid coverage for:

> inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases.[15]

If Congress had intended to limit IMDs to traditional mental hospitals, it would have provided simply that persons over age 64 were eligible for Medicaid coverage in IMDs. Connecticut's contention that IMDs can only be mental hospitals makes the reference to "inpatient hospital services" in Section 1396d(a)(14) surplusage, and at the same time it renders meaningless Congress's separate authorization for SNF and ICF services for the elderly in IMDs. Connecticut thus asks the Court to ignore the elementary principle of statutory construction that requires courts to give effect to every word that Congress has used. See, *e.g.*, *Reiter* v. *Sonotone Corp.*, 442 U.S. 330, 339 (1979).

b. Equally significant is the fact that Congress knows how to identify a traditional mental hospital in un-

[15] When this section was first enacted, the term "ICF" was not yet in use. In the Social Security Amendments of 1972, Pub. L. No. 92-603, § 297, 86 Stat. 1459-1460, the reference to ICF services was added to Section 1396d(a)(14).

mistakable terms and has done so in another section of the Medicaid statute. By amendment to the Act in 1972, Congress included within the definition of "medical assistance" for which federal financial participation is authorized "inpatient psychiatric hospital services for individuals under age 21" (42 U.S.C. 1396d(a)(16)). The Act defines "inpatient psychiatric hospital services" as "inpatient services which are provided in an institution which is accredited as a *psychiatric hospital* by the Joint Commission on Accreditation of Hospitals" (42 U.S.C. 1396d(h) (emphasis added)). If Congress had thought that IMDs were limited to traditional mental hospitals, there would have been no need for it to refer specifically to psychiatric hospitals because those hospitals would have been the only type of facility embraced within the IMD concept throughout the more than 20 years that Congress had been employing the term. Under traditional principles of statutory construction, therefore, Congress's deliberate choice of the term "psychiatric hospital" in Section 1396d(a)(16) compels the conclusion that the term IMD is not limited to traditional mental hospitals. See, *e.g.*, *Lawrence County* v. *Lead-Deadwood School Dist. No. 40-1*, No. 83-240 (Jan. 9, 1985), slip op. 10; *Fedorenko* v. *United States*, 449 U.S. 490, 512 (1981).

2. a. Connecticut does not point to a single section of the Medicaid statute that refutes the plain meaning of the sections described above. Instead, while conceding that the Act does not define IMDs, Connecticut argues that the statute contains "an express statement of what that term [IMD] does *not* include" (Br. 51-52 (emphasis in original)). Connecticut's argument is that 42 U.S.C. 1396a(a)(21)—part of the so-called "Long Amendment"—expressly prohibits ICFs from also being classified as IMDs because that provision "defines" nursing facilities (as well as community mental health centers) as "alternatives" to public IMDs.[16] Contrary to Connecticut's asser-

[16] The Long Amendment (named after Senator Long, then-Chairman of the Senate Finance Committee) actually consists of three sections of the original Medicaid statute enacted in 1965. The

tion, however, Section 1396a(a)(21) nowhere defines the term "nursing facilities." The most that can be said for this section, therefore, is that not every nursing home is a public IMD, a proposition the Secretary has never disputed. But Section 1396a(a)(21) furnishes no basis for concluding that "nursing facilities" and public IMDs, even though presumably different in many respects, are always mutually exclusive types of facilities. The real question, which Section 1396a(a)(21) does not even begin to address, is whether certain nursing facilities exhibit the "overall character" (42 C.F.R. 435.1009(e)) of an IMD.[17]

b. In the absence of any statutory provision that supports its position, Connecticut presents two principal arguments intended to overcome the force of the statutory language contained in 42 U.S.C. 1396d. Neither argument is persuasive.

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first section, 42 U.S.C. 1396d(a)(14), authorized Medicaid coverage for the elderly in IMDs. The other two provisions of the Long Amendment were the conditions Congress attached to Medicaid coverage for the elderly in IMDs (see page 4, *supra*). Briefly summarized, 42 U.S.C. 1396a(a)(20) provides that if a state chooses to include in its state plan medical assistance for the elderly in IMDs, the state must develop other forms of care for the aged mentally ill and conduct initial and periodic reviews of each elderly patient to ensure appropriate treatment for each individual. The final provision of the Long Amendment, 42 U.S.C. 1396a(a)(21), provides that if a state chooses to include in its state plan medical assistance for the elderly who are patients in public IMDs, the state must show that it is making satisfactory progress toward developing and implementing a comprehensive mental health program, "including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases." It is this last component of the Long Amendment that we discuss above in text.

[17] In addition, Section 1396a(a)(21) refers to "nursing facilities" as alternatives to care in "*public* institutions for mental diseases"; it is undisputed, however, that the IMD exclusion covers, at a minimum, private as well as public mental hospitals. See Pet. Br. 54-55 n.41. Thus, even if Connecticut's argument that the statute expressly states what an IMD is not were sufficient to overcome the clear statutory provisions previously cited, Section 1396a(a)(21) cannot be used to show that nursing facilities and *private* IMDs are mutually exclusive.

i. Connecticut contends (Br. 56-59) that the statutory definition of an ICF (42 U.S.C. 1396d(c)) supersedes the blanket IMD exclusion (42 U.S.C. 1396d(a)(B)) and authorizes Medicaid coverage for all ICF patients because the former was enacted after the latter and specifically includes care offered to patients who require it "because of their *mental* or physical condition." 42 U.S.C. 1396d(c)(1) (emphasis added). Connecticut forgets that the Secretary's interpretation of the statute does not require treating an ICF as an IMD simply because it provides mental health care to some patients; again, the focus is on the "overall character" of the facility (42 C.F.R. 435.1009(e); see Pet. App. 8a). An ICF the "overall character" of which is *not* indicative of an IMD might well provide treatment for mental conditions to patients requiring such treatment, and the facility could receive reimbursement for such services. But certain ICFs, because of their overall character, also may be IMDs. In the case of such hybrid institutions, 42 U.S.C. 1396d(a)(B) prohibits federal reimbursement for services rendered to individuals between the ages of 21 and 64.[18]

In addition, Connecticut's reliance on Section 1396d(c)'s reference to patients needing ICF care because of their mental condition is susceptible to an interpretation that fully comports with the Secretary's reading of the statute. If a state has chosen to extend Medicaid coverage to persons age 65 and over in IMDs (see 42 U.S.C. 1396a(a)(10), (20), and 21)),[19] such persons are covered for mental conditions regardless of whether treatment is provided in a hospital, an SNF, or an ICF. See 42 U.S.C. 1396d(a)(14). Thus, as the court of appeals concluded

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[18] Connecticut's "later-in-time" argument (Br. 56-57) suffers from another defect as well. The later-enacted ICF definition on which Connecticut relies (42 U.S.C. 1396d(c)) itself includes an IMD exclusion, as does Section 1396d(a)(15). The ICF provisions of the statute thus parallel, rather than supersede, the blanket IMD exclusion contained in Section 1396d(a)(B).

[19] In the period at issue here, Connecticut did not elect to extend coverage to such persons. See J.A. 24a.

(Pet. App. 8a), the language in Section 1396d(c) most probably refers to aged patients with mental illness. By the same token, the statute clearly provides coverage for the treatment of the mentally retarded in public ICFs, 42 U.S.C. 1396d(d), and the language also may apply to patients in this category (see Pet. App. 8a). In any event, the important point is that Congress nowhere expressed an intention to extend Medicaid coverage to ICFs that are engaged *primarily* in the care or treatment of the mentally ill under age 65.

ii. Connecticut's sole alternative to the ineluctable conclusion to be drawn from the plain language of the statute—that under certain circumstances an ICF can be classified as an IMD—is to draw an artificial distinction between an ICF operated *independently* of an IMD and an ICF *connected* with an IMD. Connecticut contends (Br. 53) that so long as ICF-level services are offered in independent, or "free-standing," ICFs, Congress intended that Medicaid funds be available. Only if states seek to obtain Medicaid reimbursement for ICF-level services provided in traditional mental hospitals would Connecticut concede the applicability of the IMD exclusion. For a number of reasons, this interpretation is plainly wrong.

First, as the court of appeals noted, Connecticut asks the Court to believe that, "while Congress intended to encourage the use of ICF's, it expressly forbade financial assistance to effect even the partial transformation of state mental hospitals into ICF's" (Pet. App. 9a). In support of this interpretation, Connecticut stresses Congress's desire to deemphasize reliance on traditional state mental hospitals (Br. 60-68). But this argument proves too much. As much as Congress may have looked with disfavor upon state mental institutions, there is nothing to indicate that Congress thought they could be entirely replaced by "alternative" facilities. Yet Connecticut's argument has the effect of attributing to Congress an intent to perpetuate the dismal conditions often found in state mental institutions by creating financial disincentives to their improvement. As the court of appeals emphasized

(Pet. App. 9a), "transforming part of an existing facility [into an ICF] might be considerably less expensive than development of a new institution." Connecticut's interpretation of the IMD exclusion would make this sort of cost-effective improvement sufficiently unattractive that few states would consider that option.

Second, the distinction proffered by Connecticut treats an ICF operated within an IMD differently from an independent ICF even though the nature of the patients treated and services offered are identical. Connecticut offers not the slightest support for the notion that Congress intended such an artificial distinction, which leads to wholly incongruous results. For example, Connecticut's interpretation requires the conclusion that a free-standing ICF or SNF offering solely psychiatric services to 100% of its patients at SNF or ICF levels of care can never be an IMD. Conversely, a traditional mental hospital, even if it provided only SNF or ICF services to all of its patients, could never be treated as an SNF or ICF. This single-minded focus on facilities, rather than the nature of the patients and the treatment they are receiving, has no basis in logic.

Third, Connecticut's interpretation would permit states to make a complete end-run around the IMD exclusion. States would be free to shift the burden of funding to the federal government merely by effecting wholesale transfers of mentally ill patients from larger institutions into smaller institutions that perform the same functions.[20] Indeed, the audit team in the instant action determined that "the State of Connecticut has been discharging large numbers of mentally ill patients from State mental institutions into skilled nursing facilities (SNF's) and inter-

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[20] Connecticut argues (Br. 114) that the Secretary's concern over inappropriate patient transfers is unjustified because 42 U.S.C. 1396a(a)(20)(A) (part of the Long Amendment, described at note 16, *supra*) requires states to provide "assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care." As with virtually all of Connecticut's arguments, however, this provision deals only with the

mediate care facilities (ICF's)" (J.A. 6a).[21] Even assuming that Congress has expressed a preference for ICFs over traditional mental hospitals, it has never suggested that it meant to permit the states to escape their long-standing responsibility for the care of the mentally ill simply by shifting their patient populations from bigger institutions to smaller ones.[22]

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elderly. See S. Rep. 404, *supra*, at 145 (emphasis added) ("The committee is aware that not always does a discharge plan work out to the best advantage of the patient, and thus the committee's bill provides that the agreement must make provision for the prompt readmittance to the institution where needed for the *aged person* who has been placed under an alternate plan of care."). See also pages 29, 32-33, *infra*.

[21] See also the testimony of Dr. Lawrence W. Osborne before the Departmental Grant Appeals Board given in response to a question from Connecticut's counsel as to whether Connecticut's interpretation of the IMD exclusion would result in "dumping" patients in ICF-type facilities in order to obtain federal matching funds (4/23/81 Tr. 366-367):

> I am not sure you will like the answer. * * * Conversations with the former commissioner—it is both my knowledge and judgment that Connecticut deliberately—deliberately placed people out in state psychiatric hospitals into other facilities for economic purposes—and quality care.
>
> I have absolutely no problem with the state wanting to maximize [federal financial participation]. At least, however, as a by-product of that, don't tell me quality care is in even more danger than it was in the psychiatric hospital. That was not the case in Middletown Rest Haven, but it is the case in other facilities.

[22] We note also that the frustration of congressional intent caused by patient-shifting need not be the product of state efforts to obtain federal funding to which they are not entitled. States may well conclude that transferring patients from mental hospitals to different types of facilities is in the best interests of their own mentally ill citizens, but they cannot expect federal financial support for such transfers in the absence of affirmative authorization from Congress. As Congress has long recognized, the states bear primary responsibility for the care of their mentally ill citizens.

B. The Legislative History Fully Supports The Secretary's Interpretation Of The IMD Exclusion

If any doubt remains as to the meaning of the IMD provisions of the Medicaid statute, "that doubt is removed by the legislative history." *Bankamerica Corp.* v. *United States*, No. 81-1487 (June 8, 1983), slip op. 11. We have previously traced the development of the IMD exclusion from 1950 to the present (see pages 3-6, *supra*). The point that emerges from that development is Congress's cautious, step-by-step approach to increased federal funding for the mentally ill. What further emerges from the legislative history is that Congress has not yet taken the step of authorizing Medicaid coverage for SNFs and ICFs primarily engaged in the care and treatment of the mentally ill under age 65.

1. Connecticut relies heavily (Br. 24-29, 60-71) on legislative history demonstrating Congress's intent to encourage the development of alternatives to traditional mental hospitals. That history, however, is drawn almost entirely from congressional consideration of the original IMD exclusion as it pertained to the *elderly*. As the court of appeals recognized, Connecticut's lengthy discussion of the legislative history concerning alternative types of care for the elderly "merely underlines the absence of any such history supporting Connecticut's position as to persons *under* age 65" (Pet. App. 12a (emphasis added)). In addition, congressional consideration of alternative types of care for the elderly occurred in connection with Congress's decision to lift the IMD exclusion for the elderly entirely, so that they are now eligible for mental health treatment in all types of facilities (*e.g.*, hospitals, SNFs, or ICFs). See 42 U.S.C. 1396d(a)(14); S. Rep. 404, *supra*, at 145. The absence of any similar discussion with respect to persons under age 65, coupled with Congress's failure to alter the IMD exclusion for those under age 65, is fatal to Connecticut's argument.[23]

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[23] Moreover, the fact that the ICF concept did not enter the legislation until 1967 completely undercuts Connecticut's reliance

2. The hole in Connecticut's argument cannot be attributed to mere legislative inadvertence. On the contrary, Congress has on at least three occasions rejected explicit proposals to lift the IMD exclusion for persons under age 65. Significantly, the proposals would have made Medicaid funding available for the needy mentally ill under age 65 not simply in traditional mental hospitals, but also in alternative treatment settings. See, *e.g.*, *Social Security Amendments of 1967: Hearings on H.R. 12080 Before the Senate Comm. on Finance*, 90th Cong., 1st Sess. 1741 (1967) (statement of Dr. Robert W. Gibson, American Psychiatric Ass'n) [hereinafter cited as *1967 Hearings*]; [24] *Social Security Amendments of 1970: Hearings on H.R. 17550 Before the Senate Comm. on Finance*, 91st Cong., 2d Sess. 500-550 (1970) [hereinafter cited as *1970 Hearings*]; *Social Security Amendments of 1971: Hearings on H.R. 1 Before the Senate Comm. on Finance*, 92d Cong., 1st & 2d Sess. 924-941 (1972) (statements of Dr. Jonathan Leopold, Cmm'r, Vt. Dept. of Mental Health, and Dr. Kenneth Gaver, Comm'r, Ohio Dept. of Mental Hygiene & Corrections) [hereinafter cited as *1972 Hearings*].

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on the pre-1967 legislative history. To the extent that Connecticut relies on the numerous references to mental hospitals in that pre-1967 period, it is clear that those references merely confirm that a state mental hospital is an IMD—a fact clearly not at issue here and certainly not inconsistent with the notion that an ICF also can be an IMD.

[24] Dr. Gibson urged Congress to make Medicaid funding available for those under age 65 in public mental hospitals, private psychiatric hospitals, and community mental health centers. Dr. Gibson stressed the need for coverage at all "properly qualified institutions" and explained how this would be accomplished (*1967 Hearings* 1742):

> We want the definition of a hospital to include the public mental hospital, the private psychiatric hospital, and the community mental health center.
>
> This would mean deleting the phrase "other than services in an institution for * * * mental diseases."

Congress did not adopt Dr. Gibson's suggestion.

The court of appeals discussed the significance of these hearings at length (see Pet. App. 12a-15a). It is sufficient to note here that Congress was urged to authorize Medicaid coverage for the mentally ill under age 65 not only in mental hospitals but in ICFs as well. See *1970 Hearings* 502 ("A program of care is needed at a level below that of a medically-oriented skilled nursing home. For the mentally ill this might be a supportive program of care of a semimedical nature."); see also *id.* at 505-506. As the court of appeals observed, "[t]his episode * * * suggests two conclusions: (1) Congress did not consider ICF's and IMD's as mutually exclusive categories; and (2) Congress declined to enact an ICF definition which included ICF's treating the mentally ill, although it was explicitly asked to do so" (Pet. App. 13a).

3. In addition to Congress's three post-1965 rejections of proposals to lift the IMD exclusion for the mentally ill under age 65, the legislative history of the 1972 amendments to the Medicaid program makes clear that Congress's reference to ICF services was to such services *provided in ICFs*, and not just to such services provided in traditional mental hospitals. As previously noted (see note 15, *supra*), in the Social Security Amendments of 1972, Pub. L. No. 92-603, § 297, 86 Stat. 1459-1460, codified at 42 U.S.C. 1396d(a)(14), Congress authorized Medicaid funding for ICF services for the elderly in IMDs. The Conference Report explained this amendment as follows (H.R. Rep. 92-1605, 92d Cong., 2d Sess. 64 (1972) (emphasis added)):

> The Senate amendment added a new section to the House bill which provided that when a State chooses to cover individuals age 65 and over in institutions for * * * mental diseases *it must cover such care in intermediate care facilities as well as in hospitals and skilled nursing homes.*

This passage clearly indicates that all three types of facilities—hospitals, SNFs, and ICFs—can be IMDs. The language demonstrates that Congress contemplated hybrid institutions such as Middletown Haven—institutions that,

by virtue of their overall character, are simultaneously ICFs and IMDs. If Congress had intended to limit IMDs to mental hospitals, the Conference Report would not have referred separately to each type of facility.

4. Even though Congress rejected three post-1965 proposals to lift the IMD exclusion for the mentally ill under age 65, Connecticut apparently contends that Congress actually took such action in the original Medicaid legislation passed in 1965. Connecticut again relies heavily (Br. 43-45) on the Long Amendment. As we have previously noted (see note 16, *supra*), the Long Amendment, as a condition of providing federal financial assistance for the elderly in IMDs, required participating states to demonstrate satisfactory progress in the development of comprehensive mental health programs. The legislative history of the Long Amendment plainly indicates, however, that Congress's concern was, again, with the development of alternative treatment plans for the *elderly*. The Senate Report explained the Long Amendment as follows (S. Rep. 404, *supra*, at 145-146 (emphasis added)):

> For those States that wish to take advantage of Federal participation in payments to the mentally ill who are in institutions for mental disease, the bill requires a provision for a joint agreement * * *. This agreement is intended * * * to set forth alternative methods of care, *particularly for the aged who are mentally ill.* Institutional treatment and care in the individual's own home are only two of the possible ways of caring for the *aged* who have mental problems. It is expected that the joint agreements will include plans for the use of other methods of care, such as nursing homes, short-term care in general hospitals, foster family care, and others. This legislation, it is anticipated, will give further encouragement to the trend in the States for discharging from mental hospitals to the community the *aged* who are considered able to care for themselves, under some form of protective arrangements. * * *
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> * * * * *

> The committee bill provides for the development in the State of alternative methods of care and requires that the maximum use be made of the existing resources in the community which offer ways of caring for the mentally ill who are not in hospitals. This is intended to include provisions for persons who no longer need care in hospitals and who can, with financial help and social services to the extent needed, make their way in the community. Under the 1962 Public Welfare Amendments, State public welfare agencies are encouraged to provide social services for the *aged* * * *. Under the committee bill, these social services would be made available, as appropriate, for the *aged* who are in the hospitals or who would otherwise need care in an institution.[25]

Given this clear congressional understanding that the Long Amendment dealt only with the needs of the elderly mentally ill, it is inconceivable that Congress would have authorized identical coverage for those under age 65 without ever saying so.

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[25] Significantly, mental health professionals also understood that the Long Amendment dealt only with the elderly. See *1970 Hearings* 541 (remarks of Dr. Jonathan Leopold, Vt. Comm'r of Mental Health) (emphasis added)):

> The Long amendment was very farsighted in the variety of approaches and requirements for cooperation, for program planning, for individual planning, for progress in program and programs. *But it was restricted solely to the old age assistance recipients* and, as you know, Senator, there are many, many persons under the age of 65 who are presently disabled who fit into the aid to the permanently and totally disabled category who would also benefit from such an improvement in program as well as many, needy children.

Similarly, in testifying about the perceived success of the Long Amendment, which authorized Medicaid coverage for the elderly mentally ill in all types of facilities, Dr. Leopold stated that "[t]hese [elderly] patients have been discharged into nursing homes, into intermediate-care facilities, into boarding homes, foster homes, family care, and many of them to return to live with their own families; and we think this is a very impressive record *as a result of this legislation* [the Long Amendment]" (*1972 Hearings* 928). Dr. Leopold then urged Congress to extend comparable cover-

Connecticut also relies (Br. 69) on a statement made by Senator Long in support of the 1971 legislation transferring ICF coverage to the Medicaid program (see page 5 & note 4, *supra*). Senator Long stated that "'intermediate care coverage is for persons with health-related conditions who require care beyond residential care or boarding home care, and who, in the absence of intermediate care would require placement in a skilled nursing home or mental hospital.'" 117 Cong. Rec. 44721 (1971) (citation omitted). Connecticut contends (Br. 69-70) that Senator Long's statement demonstrates Congress's intent that Medicaid funding be available for ICF services provided to all patients who otherwise would be in a mental hospital subject to the IMD exclusion. But Connecticut conveniently ignores a significant portion of Senator Long's statement. The statement described ICF care as being not only for those who would otherwise be in a mental institution, but also for those who would otherwise be in a skilled nursing home. Yet it has been Connecticut's position throughout this litigation that the IMD exclusion is as inapplicable to "free-standing" SNFs as it is to "free-standing" ICFs. Thus, Senator Long's statement simply does not support Connecticut's argument.[26]

5. The import of the legislative history is clear. The IMD exclusion was intended to block the use of Medicaid funds to help pay for the care of the mentally ill under age 65 in a broad range of institutions subsumed under the label "institution for mental diseases," including ICFs. Congress was asked repeatedly to lift the exclusion, but it has declined to do so. In these circumstances, it would be inappropriate indeed to provide Connecticut with the relief it seeks through litigation when the states have been unable to obtain that relief from Congress. See *United States* v. *New Mexico*, 455 U.S. 720, 744 (1982).

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age to the mentally ill under age 65. *Id.* at 928-929; see also Pet. App. 13a-14a.

[26] In addition, as we have demonstrated above (see pages 32-33, *supra*), Senator Long's amendment dealt with ICF services for the elderly and thus not subject to the IMD exclusion in any event.

C. The Secretary's Interpretation Of The IMD Exclusion Is Entitled To Deference

Despite the clear import of the statutory language and the legislative history, Connecticut argues (Br. 108-118) that the Secretary's interpretation of the IMD exclusion should be disregarded because it is allegedly inconsistent with congressional intent and because HHS allegedly has not adhered to a consistent administrative interpretation of the IMD exclusion. Neither contention is correct.

1. Connecticut contends that the Secretary's interpretation of the IMD exclusion conflicts with congressional intent because Congress actively sought to promote the use of "alternatives" to traditional mental hospitals, while the Secretary's interpretation would eliminate any incentive to develop alternatives such as ICFs and SNFs by making Medicaid coverage unavailable for patients in ICF/IMDs or SNF/IMDs. Connecticut's argument is flawed for a number of reasons.

First, traditional mental hospitals are no longer the "dumping grounds" Congress sought to discourage, a fact of which this Court has taken notice. *Pennhurst State School & Hospital* v. *Halderman*, No. 81-2101 (Jan. 23, 1984), slip op. 18 n.16. Both public and private mental hospitals now provide active, therapeutic treatment for their patients, and custodial, room and board "care" is largely a thing of the past. Indeed, as early as 1970, Congress was told that "[m]odern state mental hospital services are not custodial but, rather, are treatment-oriented to the limit of their resources." *1970 Hearings* 511 (statement of Dr. Gaver). Similarly, Dr. Leopold told the Senate Finance Committee that "[y]our committee has heard about 'human warehouses,' and many of our State hospitals were such places. They are no longer." *Id.* at 532. Mr. Schnibbe, the Executive Director of the National Association of State Mental Health Program Directors, explained the improvements in greater detail (*id.* at 538):

> The notion that the States as a whole are still operating custodial facilities is fal[l]acious.

> Now, it still persists in places. Both of these doctors here today would probably say they know of a couple of instances around the country where it is still true.
>
> The point is that right now this is generally a fal[l]acious notion.
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> • • • • •
>
> It might have been true 30, 40, 50 years ago. It is not true today because some of the finest, most progressive, most exciting mental hospitals are State-operated programs in Little Rock, Ark., and Denver, Colo., and other State facilities all over the country.

See also Br. of Amici Curiae Illinois, California & Minnesota 8; *1970 Hearings* 539-541; M. Levine, *From State Hospital to Psychiatric Center* (1980); Ahmed, *Whither the State Hospital? Issues and Trends in Mental Health Services Delivery*, in *State Mental Hospitals* 208 (P. Ahmed & S. Plog ed. 1976); H. Gottesfeld, *Alternatives to Psychiatric Hospitalization* 23-34 (1977).[27]

With these improvements in the treatment offered to patients at traditional mental hospitals—improvements that were brought to Congress's attention over a decade ago—it is reasonable to assume that Congress would have acted to lift or relax the IMD exclusion insofar as it applies to mental hospitals, at least to a degree commensurate with the improvement in treatment now offered by those facilities. That it has not done so strongly suggests that Congress's concern extended beyond distrust of the old state mental institution and embraced fiscal considerations to at least an equal degree. Connecticut's crabbed interpretation of the IMD exclusion would totally undermine Congress's concern for the public fisc. If such a large, additional expenditure of public monies is to be undertaken, it should occur only as the result of clear congressional authorization.[28]

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[27] The last-cited book contains a table (H. Gottesfeld, *supra*, at 34) showing the changes in mental hospitals from the 1950's to the 1970's. The table is reproduced as Appendix B to this brief.

[28] That Congress is fully capable of responding to changed circumstances if it so chooses is amply demonstrated by the Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, § 2335(f), 98 Stat. 1091. Prior to the passage of this statute, the Medicaid program had excluded coverage (except for those over age 64) in institutions for tuberculosis, as well as in IMDs. The 1984 amendment deleted the tuberculosis exclusion entirely. Although the legislative history of the amendment is quite sparse (see H.R. Rep. 98-861, 98th Cong., 2d Sess. 1327 (1984)), it may reasonably be assumed that Congress was aware both that tuberculosis is less common today than it once was and that it responds to treatment with antituberculosis medication. If Congress had come to a similar conclusion about mental illness, it could have removed the IMD exclusion at the same time that it eliminated the tuberculosis exclusion. That it did not do so undoubtedly reflects Congress's awareness that mental illness shows no signs of abating and that effective short-term treatment remains problematic in significant numbers of cases. For the time being, therefore, it is clear that Congress has chosen to leave primary responsibility for the care of the mentally ill where it always has been—with the states.

Second, while we do not dispute Congress's desire to replace (where appropriate for the patient) outdated traditional mental hospitals with newer, more treatment-oriented and community-based facilities, there is strong evidence to suggest that the move away from mental hospitals into "alternative" treatment settings has not always been as beneficial for patients as had been hoped. The process of transferring patients out of mental hospitals is commonly referred to as "deinstitutionalization." What is less commonly known is the phenomenon of "reinstitutionalization," whereby patients are transferred from state mental hospitals to nursing homes that in fact provide care that is little, if any, better than the custodial care previously offered by mental hospitals.[29]

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[29] See, *e.g.*, U.S. Comptroller General, *Rep. No. HRD-76-152, Returning the Mentally Disabled to the Community: Government Needs to Do More* 14, 16 (1977); Goldman, Adams & Taube, *Deinstitutionalization: The Data Demythologized*, Hospital & Community Psychiatry 129, 134 (Feb. 1983) (citations omitted) ("Clearly, a large proportion of current nursing home residents would have been state mental hospital patients before deinstitutionalization. However, many observers consider this shift to nursing-home care to be not deinstitutionalization, but reinstitutionalization—a new custodialism replete with its own failures and

If, as Connecticut argues (and we agree), Congress did not want to authorize Medicaid coverage for custodial care of the mentally ill in traditional mental hospitals, then there certainly is no reason to suppose that Congress would have wanted Medicaid funds to go to "alternative" facilities that were no better than the traditional institutions they were replacing.[30] In these circumstances, the Secretary's interpretation of the IMD exclusion is fully consistent with congressional intent.

Third, there is no merit to Connecticut's argument (Br. 116-117) that the Secretary's interpretation of the IMD exclusion focuses on the mental diagnoses of a majority of the patients and thereby conflicts with the statutory policy against discrimination in the Medicaid program on the basis of diagnosis (42 U.S.C. 1396a(a)(10)) or the prohibition against discrimination on the basis of

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shortcomings.); Stotsky & Stotsky, *Nursing Homes: Improving a Flawed Community Facility*, Hospital & Community Psychiatry 238, 241 (Mar. 1983) (citations omitted) ("A significant number of patients enter nursing homes with psychiatric diagnoses. In fact, psychiatric disturbances are probably the predominant form of illness in nursing homes, and yet psychiatric care in these homes is generally deficient. Dittmar and Franklin found that three years after a group of patients were placed in a nursing home from a state hospital, less than one-third of the group showed adequate mental functioning."); M. Levine, *From State Hospital to Psychiatric Center* 3 (1980) ("Deinstitutionalization and community mental-health programming, initially greeted with enthusiasm, were quickly subject to devastating criticism as journalistic exposes * * * and legislative inquiry * * * uncovered abuses. Patients were released to nursing homes, to board-and-care homes, or to welfare hotels with little planning and little possibility for after-care. This phenomenon, which might have resulted in the premature deaths of some older, frail patients * * *, came to be called 'dumping.'").

[30] We recognize that particular facilities, including Middletown Haven, may in fact be offering beneficial treatment to their patients (see, *e.g.*, J.A. 45a-46a). But Congress may reasonably make programmatic judgments concerning the wisdom of funding particular *types* of facilities, even though certain facilities may not exhibit the general characteristics of the particular category at issue. See *Schweiker* v. *Gray Panthers*, 453 U.S. at 48; *Schweiker* v. *Wilson*, 450 U.S. 221, 234-235, 238-239 (1981).

handicap contained in the Rehabilitation Act of 1973, 29 U.S.C. 794. To begin with, the Secretary's regulation and criteria focus on a broad array of factors covering all aspects of a facility, and not merely on the percentage of patients with diagnoses of mental illness. See note 36, *infra*. In addition, neither the regulation nor the criteria work any discrimination based on handicap. The *statute* states, quite simply, that federal financial assistance is prohibited for services provided in IMDs. Thus, as Connecticut points out (Br. 117), even residents of nursing facilities who are afflicted only with physical disorders are ineligible for Medicaid coverage if they are placed in a facility that is both an ICF and an IMD. The IMD exclusion applies to facilities, rather than to patients (except those over 64), and thus it applies equally to those with mental illness and those without.

This does not mean that the mentally ill are rendered ineligible for Medicaid on the basis of their handicap. Rather, the statute merely limits the types of facilities in which they may receive covered services, much like the certification standards for SNFs and ICFs limit the choice of nursing homes available to Medicaid recipients (see 42 U.S.C. 1395x(j) and 1396d(c)). See generally *O'Bannon* v. *Town Court Nursing Center*, 447 U.S. 773 (1980). Thus, the eligible mentally ill may receive covered services in a general hospital, general SNF, or general ICF. Similarly, they have access to the full range of outpatient services covered by Medicaid. The only limitation, and the limitation intentionally imposed by Congress, is that Medicaid coverage may not be provided for services in IMDs. To paraphrase this Court's holding in *Schweiker* v. *Wilson*, 450 U.S. 221, 232 (1981), the distinction here is "not between the mentally ill and a group composed of nonmentally ill," but rather between residents of IMDs and residents of other long-term care facilities. Such a distinction does not discriminate on the basis of handicap.

Finally, Connecticut ignores the fact that Congress *has* provided for the needs of the mentally ill between the

ages of 21 and 64 through the Community Mental Health Centers program.[31] Indeed, it was this very program that the Long Amendment sought to encourage, rather than expanded reliance on Medicaid, when, as a condition of extending IMD coverage to the elderly, Congress required

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[31] The Community Mental Health Centers Act, enacted in 1963, Pub. L. No. 88-164, Tit. II, 77 Stat. 290 *et seq.*, authorized federal funding for the construction of community mental health centers (CMHCs). The House and Senate Reports on the Act emphasized that it was intended to promote alternatives to the custodial care traditionally provided in state mental institutions. See H.R. Rep. 694, 88th Cong., 1st Sess. 12 (1963); S. Rep. 180, 88th Cong., 1st Sess. 10 (1963). In 1965, Congress extended the time period for funding the construction of CMHCs and also for the first time authorized funds to be used to staff the centers. Pub. L. No. 89-105, 79 Stat. 427 *et seq.* Staffing grants were provided "on condition that the recipient community has a program providing at least the essential elements of comprehensive mental health services," including "[i]npatient services, outpatient services, emergency services, and consultation and education services." S. Rep. 366, 89th Cong., 1st Sess. 5, 6 (1965). The Act was extended by Congress on several subsequent occasions, and the list of required "essential services" was expanded. See 42 U.S.C. 2681 *et seq.* (repealed) codification note.

In 1980, Congress enacted the Mental Health Systems Act, Pub. L. No. 96-398, 94 Stat. 1564 *et seq.*, which again specified essential services that CMHCs were required to provide. This Act also provided grants for the care of chronically mentally ill individuals whose needs "have not been adequately met by the CMHC program." S. Rep. 96-712, 96th Cong., 2d Sess. 35 (1980).

In 1981, Congress repealed the Community Mental Health Centers Act and the Mental Health Systems Act and integrated both programs into a system of block grants to the states. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 902, 95 Stat. 560, codified at 42 U.S.C. 300x *et seq.*, as amended by Pub. L. No. 98-509, 98 Stat. 2353. The new mental health services block grant program requires participating states to continue funding community mental health services, including services for the chronically mentally ill of all ages. 42 U.S.C. 300x-4(e). Unlike the earlier categorical grants under the Community Mental Health Centers Act and the Mental Health Systems Act, however, the block grant statute specifically prohibits states from spending federal funds on inpatient services for the mentally ill. 42 U.S.C. 300x-3(b)(1).

participating states to demonstrate satisfactory progress in developing and implementing comprehensive mental health programs. See page 4, *supra*. At the same time, however, Congress has been reluctant to appropriate the enormous amounts of money that might be required to make the CMHC program as comprehensive as the states would like. Initially, the CMHC program was intended to provide only "seed money" for the states to undertake construction of CMHCs. Although the program was later expanded to include funds for staffing and operating expenses (see note 31, *supra*), Congress has never funded the program as liberally as it has funded Medicaid. Moreover, Congress intentionally prohibited the states from continuing to use CMHC funds for inpatient services when it repealed the original statute and melded the program into a comprehensive block grant program. *Ibid.*

Congress's concern with cost has become even greater in recent years. The Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357 *et seq.*, which made the CMHC program part of a health services block grant, was intended to reduce "by more than one-half [] the average annual growth in Federal spending in the past 5 years." S. Rep. 97-139, 97th Cong., 1st Sess. 2 (1981). The health services block grant was intended to facilitate a reduction of 20 to 25% in federal funding for the affected programs. See *id.* at 869. This concern was repeated in the 1984 amendments to the block grant program, when the Senate noted the "need to limit Federal spending at a time of large deficits." S. Rep. 98-381, 98th Cong., 2d Sess. 8 (1984).

In short, Connecticut asks this Court to interpret the IMD exclusion in a manner that would impose enormous costs on the federal government in the absence of any indication that Congress ever agreed to assume such costs and in the face of recent evidence that it instead acted intentionally to reduce federal spending for the care of the mentally ill between the ages of 21 and 64. If the states are unhappy with the level of federal spending for mental health care, their remedy lies with Congress, and not with the courts.

2. Connecticut's argument that HHS has in some way changed its interpretation of the IMD exclusion is completely unfounded. As previously noted (see page 6, *supra*), the agency made clear in the 1966 *HPA*, immediately after the Medicaid program was first enacted, that the focus of the IMD exclusion was on the "overall character" of a facility as one "established and maintained primarily for the care and treatment of individuals with mental diseases" (*HPA* ¶ D-4620.2). Subsequent regulations have repeated the same definition. See pages 7-8, *supra*. Such a long-standing administrative interpretation, based on a contemporaneous construction of a statute by those " 'charged with the responsibility of setting its machinery in motion, of making the parts work efficiently and smoothly while they are yet untried and new,' " is entitled to the greatest deference. *Aluminum Co. of America* v. *Central Lincoln People's Utility Dist.*, No. 82-1071 (June 5, 1984), slip op. 8 (citations omitted).

The only basis for Connecticut's contrary argument is the portion of the 1966 *HPA* that defined an IMD as an institution meeting the requirements of a psychiatric hospital as set forth in the Social Security Act (see note 6, *supra*). But that portion of the *HPA* in no way undermines the general focus on the "overall character" of a facility because, in 1966, ICF services were not even covered under the Social Security Act, skilled nursing facilities specializing in the care and treatment of the mentally ill were few and far between, and the *HPA* definition of SNF services itself precluded Medicaid coverage for the care and treatment of inpatients with mental diseases. *HPA* ¶ D-5141.4 provided as follows (emphasis added):

> *Skilled Nursing Home Services (Other Than Services in an Institution for * * * Mental Diseases) for Individuals 21 Years of Age or Older*
>
> This term is defined as those items and services furnished by a skilled nursing home *maintained primarily for the care and treatment of inpatients with disorders other than * * * mental diseases* which are provided under the direction of a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law.

Notwithstanding the 1966 *HPA*'s definition of an IMD as a psychiatric hospital, therefore, it is clear from other provisions of the *HPA* (and subsequent regulations) that the agency always has looked to the overall character of an institution. That the agency has not wavered from its interpretation is demonstrated by the fact that, as SNFs and ICFs specializing in the care and treatment of the mentally ill became increasingly common, the agency's regulations were amended to delete the provision defining an IMD as a psychiatric hospital. Compare 45 C.F.R. 249.10(b)(14)(iv) (1973) with 45 C.F.R. 249.10(b)(14)(iv) (1974). Accordingly, the agency's consistent and contemporaneous interpretation of the IMD exclusion should be upheld by this Court.

D. The Facts Of This Case Demonstrate Why Congress Could Not Have Intended To Limit IMDs To Traditional Mental Hospitals

1. The facts of this case well illustrate the illogic in Connecticut's position that only a mental hospital can be an IMD. The factual findings of the audit team, set forth at pages 11-13, *supra*, lead to one inescapable conclusion: "That which looks like a duck, walks like a duck, and quacks like a duck will be treated as a duck even though some would insist upon calling it a chicken." *Tidelands Marine Service* v. *Patterson*, 719 F.2d 126, 128 n.3 (5th Cir. 1983). In other words, there can be no doubt that Middletown Haven, even though certified as an ICF, was "primarily engaged in providing diagnosis, treatment or care of persons with mental diseases." 42 C.F.R. 435.1009(e).

Connecticut does not dispute the findings of the audit team but nevertheless contends that the applicability of the IMD exclusion turns on the formal label applied to a facility, regardless of its factual characteristics.[32] Such a

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[32] Although Connecticut does not dispute the audit team's findings, it does contend that the guidelines used by the reviewers

mechanistic approach would completely frustrate Congress's decision *not* to provide Medicaid coverage in IMDs for the mentally ill between the ages of 21 and 64. Connecticut has utterly failed to demonstrate that Congress has abandoned its long-held view that the care and treatment of such persons is a state responsibility, yet Connecticut's position would allow states to transfer a large portion of the responsibility for those very persons to the federal government.

A brief review of the criteria used by the Secretary to identify IMDs (see page 9, *supra*) demonstrates the unworkability of placing IMDs and ICFs into watertight compartments. While varying widely in relative importance, all ten criteria are rationally related to identifying IMDs; indeed, the relevance of the majority of the criteria is self-evident. For example, the medical profile of a facility's patients is of obvious importance in determining the "overall character" of the institution. The audit team found that an overwhelming number (77%) of the patients at Middletown Haven had diagnoses of mental diseases (J.A. 17a). Similarly, the staffing patterns (psychiatrists and non-medical personnel specially trained to care for the mentally ill (J.A. 22a-23a)), the heavy use of psychotropic drugs (J.A. 23a), and the staff's own perception that Middletown Haven is a psychiatric facility (J.A. 14a) are obviously relevant in determining the "overall character" of an institution.

The number of patients admitted to an ICF from state mental hospitals also is important, particularly where, as in this case, the record shows that large numbers of those patients either were returned to the mental institution from which they had come or transferred to other institutional settings. Very few were returned to community living, thus strongly supporting the finding that Middle-

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were "nonspecific criteria of doubtful validity" (Br. 94 (footnote omitted)). But the "validity" of the guidelines is not before the Court; the only question presented is whether, as a matter of statutory construction, an ICF can ever be an IMD. See Pet. i; see also page 48, *infra*.

town Haven was used as a facility for persons who actually required care and treatment in a mental institution. See J.A. 17a-18a. Similarly, another criterion, age distribution uncharacteristic of nursing home patients (a preponderance of patients under age 65), is significant because nursing home residents with physical ailments tend as a group to be older than patients with mental disabilities. See J.A. 20a. The relevance of the institution's license to care for individuals with psychiatric conditions is clear (J.A. 13a-14a).

All of these factors clearly support the audit team's ultimate determination that Middletown Haven "is primarily engaged in providing psychiatric services to residents with a mental illness" (J.A. 24a). Common sense compels the conclusion that such a facility must be classified as an IMD.

2. Every other court that has considered the meaning of the IMD exclusion has rejected the notion that ICFs can never be IMDs. Connecticut's contrary contention (Br. 4) is simply erroneous.[33] It is true that the courts that have considered the matter have reached varying results, but not on the sole issue that is before this Court —whether the IMD exclusion is limited to traditional mental hospitals.

For example, Connecticut erroneously contends (Br. 82 n.62) that the Eighth Circuit held in *Minnesota* v.

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[33] Nor is the decision in *Schweiker* v. *Wilson*, 450 U.S. 221 (1981), of any assistance to Connecticut. In *Wilson*, the Court did not rule that IMDs and ICFs are mutually exclusive categories of institutions. Indeed, the Court did not even address the issue of the definition of the term "institution for mental diseases." Instead, the Court addressed the constitutionality, under equal protection principles, of a statute excuding from Supplemental Security Income benefits those residents of public mental institutions who are subject to the IMD exclusion. Connecticut therefore errs in relying (Br. 80-81) on references in both the majority and dissenting opinions in *Wilson* to selected portions of the legislative history of the IMD exclusion, because that history merely confirms that a state mental hospital is an IMD—a fact clearly not at issue here and certainly not inconsistent with the notion that an ICF also can be an IMD.

Heckler, 718 F.2d 852 (1983), that ICFs and IMDs are mutually exclusive. In fact, the Eighth Circuit clearly recognized that IMDs may encompass a broad range of care and treatment (718 F.2d at 866; Pet. App. 23e):

> IMD treatment may * * * include a higher degree of care and treatment than is provided by facilities which only offer SNF or ICF services. However, based on legislative history, it may also include custodial 'room and board' care which is not aimed at simultaneously providing active or therapeutic treatment leading to cure.

This statement would have been totally unnecessary had the Eighth Circuit thought that IMDs and ICFs were mutually exclusive types of facilities.[34]

Moreover, the decision of the United States District Court for the District of Minnesota that the Eighth Circuit affirmed also ruled that an IMD can be a facility other than a mental hospital. *Minnesota* v. *Schweiker*, No. 4-82-155 (Aug. 25, 1982). The district court concluded that "[t]here is no inherent logic to the position that an institution for mental diseases can only be a mental hospital." Slip op. 9. The district court further held that if "an institution provided solely psychiatric services at a SNF level of care to 100% of its patients, it would be an IMD. Similarly, *the State cannot relocate mentally ill persons from one institution to a number of smaller institutions and provide approximately the same care and hope to avoid the operation of the IMD exclusion.*" Slip op. 14 (emphasis added).

The district court in the instant case also recognized that an ICF can be classified as an IMD. See Pet. App. 5c, 7c. Furthermore, the district court defined an IMD

[34] Connecticut has argued that the Secretary's reliance on this passage is misplaced. Connecticut contends (Reply Br. 2 n.2) that the Eighth Circuit meant only that a facility could be classified as an IMD if its residents required the *intensive* level of psychiatric or custodial care characteristic of mental hospitals. But nowhere did the Eighth Circuit state that IMD care is in all cases more "intensive" than ICF care; on the contrary, the passage quoted above clearly suggests the opposite conclusion.

as including the care given to "a nursing home resident" (*id.* at 7c n.9), even though Connecticut contends that ICFs and SNFs can never be IMDs.[35] Finally, the United States District Court for the Northern District of Illinois expressly stated that it was not "hold[ing] that the categories of IMD and ICF are mutually exclusive." *Illinois* v. *United States Dep't of Health and Human Services*, No. 82-C-1349 (Mar. 20, 1984), slip op. 3 n.1, appeal pending, No. 84-2615 (7th Cir.); Pet. App. 3f n.1.[36]

[35] Inexplicably, however, the district court proceeded to reject its own statutory analysis in favor of its self-created "total care" concept (see note 11, *supra*).

[36] To be sure, as Connecticut points out (Br. 101), the decisions cited above differ to some extent from the decision of the court of appeals in this case. But the differences stem from the courts' differing evaluations of the supplemental criteria used by the Secretary to determine whether an institution (including an ICF) warrants classification as an IMD—an issue not before this Court. Moreover, even as to the criteria, the differences are more semantic than real. For example, the court below stated that "the IMD exclusion virtually compels HHS to focus on the nature of the illness treated rather than the care furnished" (Pet. App. 16a), whereas the Eighth Circuit stated that "the characterization of an IMD must fundamentally center on the type of care or nature of services *required*, not on the mere presence in a facility of patients who have, or at one time did have, diagnoses of a mental disease" (718 F.2d at 863; Pet. App. 17a (emphasis added)). As a practical matter, however, the Eighth Circuit's focus on "care and treatment" does not constitute a significant departure from the Second Circuit's focus on diagnoses. Thus, in most, if not all, cases (including this one), ICFs that qualify as IMDs under the Second Circuit's approach because they contain large numbers of patients who suffer from mental diseases also will be found to be IMDs under the Eighth Circuit's approach because extensive mental health care and treatment would be required in such facilities.

In any event, most of the ten criteria that the Secretary uses to supplement her regulation in making the determination whether the overall character of an institution warrants treatment as an IMD do not focus on diagnoses. See page 9, *supra*. We note in this regard that the psychiatrist who led the audit team at Middletown Haven gave testimony before the Departmental Grant Appeals Board concerning the types of mental health services provided at

II. THE DISALLOWANCE AT ISSUE DOES NOT CONTRAVENE THE CONCEPTS OF "FEDERALISM" THAT UNDERLIE THE MEDICAID PROGRAM

A. Connecticut's "Federalism" Argument Is Not Properly Before The Court

Contending that the states lacked meaningful advance notice of HHS's interpretation of the IMD exclusion, Connecticut argues that the disallowance of federal funds in the instant action "undermines the federalism concept on which the public assistance programs are based" (Br. 93). This issue is not properly before the Court because it is not even remotely subsumed within the question presented in Connecticut's petition for a writ of certiorari (see Pet. i, 4).[37] See, *e.g.*, *Irvine* v. *California*, 347 U.S. 128, 129 (1954) (disapproving of the practice of "smuggling additional questions into a case after [the Court] grant[s] certiorari").

Nor can it be contended that Connecticut's new argument simply advances policy reasons in support of its position that IMDs and ICFs are mutually exclusive. On the contrary, Connecticut's "federalism" argument, if accepted by this Court, could result in a reversal of the disallowance for Middletown Haven even if the Court were to agree with the court of appeals on the question actually presented. Thus, the "federalism" issue is not fairly subsumed within the question presented, and it should not be considered by this Court.

Middletown Haven in support of his conclusion that the facility was an IMD. See J.A. 20c-21c; 24c-25c; C.A. App. 79-81, 91. The determination that Middletown Haven was an IMD therefore did not depend solely on the diagnoses of the patients.

[37] Moreover, the court of appeals did not address the issue. This is not surprising because Connecticut did not identify the issue as a question presented, and its brief (at 36-37) contained only a passing citation to *Pennhurst State School & Hospital* v. *Halderman*, 451 U.S. 1 (1981). This was hardly sufficient to bring the issue to the lower court's attention.

B. Connecticut's "Federalism" Argument Is Erroneous In Light Of The Statute And The Record In This Case

1. Even if Connecticut's "federalism" argument were properly before the Court, it is erroneous. Connecticut first maintains (Br. 93-102) that the disallowance at issue was based on new and uncertain policies not implemented until after the federal funds were received and spent. But Connecticut provides its own rebuttal to this argument. Connecticut candidly admits that it "became aware of the issue of the extension of the IMD exception to SNFs and ICFs *in 1976*" (Br. 95 n.74 (emphasis added)). Even if one were to assume (which we do not) that the IMD exclusion was *extended* to SNFs and ICFs in 1976, the Secretary's interpretation existed before the 1977-1979 period at issue in this case and Connecticut knew it. Moreover, even if Connecticut did not have notice of all of the criteria used to determine whether a facility was an IMD (see page 9, *supra*), those criteria were mere guidelines that focused audit teams on the factors to be considered in determining whether the "overall character" of an institution established that it was an IMD. See Pet. App. 30d-31d. Thus, the criteria served to implement an IMD policy that has been clear and consistent since 1966. See pages 42-43, *supra*.

Furthermore, Connecticut has never challenged the Secretary's regulatory definition of IMDs (42 C.F.R. 435.1009(e)). That definition is without doubt broad enough to encompass ICFs and SNFs. Thus, there is no merit to Connecticut's contention (Br. 98-99 & n.78) that the regulation did not give "meaningful notice" that an ICF or SNF could be classified as an IMD, especially in view of Connecticut's concession (Br. 95 n.74) that it knew of HHS's policy in 1976.

2. Connecticut's argument apparently is also based on the fact that, even though HHS knew that Middletown Haven had been certified by the State as an ICF, the agency did not disallow payments immediately. But this demonstrates no more than the fact that Middletown

Haven can be an ICF and, depending on its other characteristics, an IMD as well. It was for the purpose of making the IMD determination that the audit involved here was conducted.

In conducting the audit and determining that the challenged disallowance was required, HHS did not alter its position as to the facility in question. Rather, the agency followed the reimbursement procedure required by statute, pursuant to which states participating in the Medicaid program are advanced funds prior to the quarters for which they are to be expended based on the states' estimate of reimbursable expenditures. 42 U.S.C. 1396b(d)(1). Only after expenditures were actually incurred by Connecticut could HHS have undertaken the audit it conducted in this case to determine whether those expenditures were, in fact, reimbursable. Adjustments based on such audits are not only contemplated but are required by statute; 42 U.S.C. 1396b(d)(5) states unequivocally that the "Secretary *shall* offset [the overpayment or disallowance] from any subsequent payments made to [the] State under this subchapter" (emphasis added).

The certification of Middletown Haven as an ICF was an action taken solely by Connecticut; that certification did not (and could not) bind the Secretary on the question whether Middletown Haven also should be classified as an IMD. When Middletown Haven was audited and was determined to be ineligible for reimbursement because it was an IMD, the Act required recoupment. A ruling such as Connecticut requests would prevent an agency from recovering grant funds that, after audit, are discovered to have been improperly paid. Such a result is clearly inappropriate and contrary to the Act itself. See *Bell* v. *New Jersey*, 461 U.S. 773, 780-783 (1983).[38]

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[38] Connecticut's reliance (Br. 103-108) on *Pennhurst State School & Hospital* v. *Halderman*, 451 U.S. 1 (1981), is misplaced for the reasons explained in our brief in *Sec'y of Education* v. *Kentucky*, No. 83-1798 (argued Jan. 8, 1985). We are furnishing a copy of that brief to petitioner's counsel. We note also that the correct disposition of the instant case does not depend in any way upon the Court's decision in *Sec'y of Education* v. *Kentucky*, *supra*. In light of Connecticut's admission that it knew of the Secretary's IMD policy at least since 1976, there can be no claim that its subsequent, erroneous interpretation of that policy was "reasonable."

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted.

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APPENDIX A

Relevant provisions of the Medicaid statute, Title XIX of the Social Security Act, 42 U.S.C. 1396 *et seq.*, as further amended by the Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, 98 Stat. 1061 *et seq.*, are as follows:

1. Section 1905(a) of the Social Security Act, 42 U.S.C. 1396d(a), as further amended by the Medicare and Medicaid Budget Reconciliation Amendments of 1984, Pub. L. No. 98-369, § 2335(f), 98 Stat. 1091, provides in pertinent part:

> Medical Assistance
>
> The term "medical assistance" means payment of part or all of the cost of the following care and services * * * for individuals * * *
>
> (1) inpatient hospital services (other than services in an institution for mental diseases);
>
> * * * * *
>
> (4)(A) skilled nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older; * * *
>
> * * * * *
>
> (14) inpatient hospital services, skilled nursing facility services, and intermediate care facility services for individuals 65 years of age or over in an institution for mental diseases;
>
> (15) intermediate care facility services (other than such services in an institution for mental diseases) for individuals who are determined * * * to be in need of such care;
>
> (16) effective January 1, 1973, inpatient psychiatric hospital services for individuals under age 21 * * *;
>
> * * * * *

except as otherwise provided in paragraph (16), such term does not include * * (B) any such payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases.

2. Section 1905(c) of the Social Security Act, 42 U.S.C. 1396d(c), provides in pertinent part:

> For purposes of this subchapter the term "intermediate care facility" means an institution which (1) is licensed under State law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities * * *. The term "intermediate care facility" also includes any skilled nursing facility or hospital which meets the requirements of the proceeding [*sic*] sentence. * * * With respect to services furnished to individuals under age 65, the term "intermediate care facility" shall not include, except as provided in subsection (d) of this section, any public institution or distinct part thereof for mental diseases or mental defects.

APPENDIX B

Set forth below is a table summarizing the differences between the traditional mental hospital of the 1950s and the typical, progressive mental hospital of the 1970s. The table appears in H. Gottesfeld, *Alternatives to Psychiatric Hospitalization* 34 (1977).

CHANGES IN MENTAL HOSPITALS

Typical Mental Hospital 1950s	*Typical, Progressive Mental Hospital, 1970s*
1. Large inpatient population	1. Smaller inpatient population.
2. Long term stay	2. Short term stay
3. Many physical restraints (barred windows, locked wards, camisoles)	3. Few physical restraints
4. Authoritarian planning. Plans and decisions are made by hospital and clinical administrators.	4. More democratic planning Patients and staff have say in certain activities and decisions.
5. Enforced, routine schedule. All patients do same activities at same time.	5. A variety of programs and individualized treatments suited to patient's needs. Some programs are voluntary.
6. Discipline arbitrary, sometimes brutal. Beatings are not rare.	6. Formal hearing required for disciplinary action. Beatings rare, often followed by an investigation.
7. Psychosurgery and electroconvulsive therapy (ECT) common treatment modalities.	7. Psychosurgery, rare; electroconvulsive therapy rarely utilized with patients other than extremely depressed patients. Both treatments require informed consent and are subject to professional review.
8. Patients exploited doing menial work for hospital. Patients may receive hospital "privileges" for work.	8. Patients paid for hospital work. Hospital often has community employment or work training.

9. Personal possessions discouraged. Patients issued hospital clothing and supplies for their needs. Patients not allowed to keep money on ward.	9. Personal possession encouraged. Patient keeps his own clothes, money, other items.
10. Little privacy. Patient observed closely on ward. Visits by others are supervised, mail opened and censored, use of telephone requires permission.	10. Much more privacy. Patient may have private or semi-private room. There is a private visiting area, no censorship of mail and access to telephone is unrestricted.

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